STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005068	A. BUILDING: _____ B. WING _____	06/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY HOSPITAL EAST	1500 N RITTER AVE INDIANAPOLIS, IN 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for investigation of one (1) State hospital complaint. Complaint Number: IN 00149797 Unsubstantiated: Lack of sufficient evidence. Date: 6-23-14 Facility Number: 005068 Surveyor: Brian Montgomery, RN, BSN Public Health Nurse Surveyor Community Hospital East is in compliance with 410 IAC 15-1.5-6 Nursing service, Hospital Licensure Rules. QA: claughlin 06/30/14	S 000		